TEACHERS' RETIREMENT SYSTEM OF KENTUCKY

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SERVING KENTUCKY TEACHERS SINCE 1940

MEMORANDUM

TO: KTRS Retirees

FROM: KTRS Insurance Department

RE: Adding Dependents

Outside of open enrollment, retirees may be allowed to add a spouse and/or dependents to their plan ***IF a qualifying event has occurred and the required application/form is signed within 35 days.***

If a qualifying event has occurred, you should complete the attached "Dependent ADD Form" and return it ***with the required Verification Documentation (see below) and QE documentation (see QE chart)***.

Person Being Added	Verification Documentation Required
Spouse	A legible photocopy of the Marriage Certificate **OR** a legible photocopy of the top half of the front page of the retiree's most recent federal tax return (Form 1040).
Common Law Spouse	A legible photocopy of the Certificate or Affidavit of Common Law Marriage from a state that recognizes Common Law Marriage.
Child Age 0 to 18	**Natural Child**: A legible photocopy of the child's birth certificate showing the name of the retiree as a parent. **Step Child**: A legible photocopy of the child's birth certificate showing the name of the retiree's spouse as a parent; **and** a legible copy of the marriage certificate showing the names of the retiree and the spouse. **Legal Guardian, Adoption, Grandchild(ren) or Foster Child(ren)**: Legible photocopies of Court Orders, Guardianship Documents, Affidavits or Dependency, with the presiding judge's signature and filed status; **or** legible Adoption or Legal Placement Decrees with the presiding judge's signature.
Child Age 19 to 25	Must submit the documents described above for children **and** the **Kentucky Employees' Health Plan 2011 Certification of Dependent Eligibility** form (attached below).
Disabled Dependent	Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed

If documentation is required and not provided, your application cannot be processed. Please review the chart and sign the application appropriately to avoid double coverage or a lapse in coverage. The application must be signed no later than 35 days from the qualifying event.

NOTE: If your qualifying event allows you to change your Option (Standard PPO, Capitol Choice, Optimum PPO), and you desire to do so, you must download an ***application*** instead of an Add Form.

If you have any questions, please contact our office.

QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO ADD/ENROLL				Rev 11/09
Event	**Event Description**	**FORM REQUIRED**	**DOCUMENTATION REQUIRED**	**Effective Date**
Change in Legal Marital Status				
Marriage	Add retiree and/or spouse and dependents (1)(5)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	None	1st day 1st month following the employee signature date
Divorce, Legal separation, annulment	Add retiree and dependents (1) if event causes loss of coverage under spouse's plan (1)(5)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	Proof of loss of other coverage (13)	1st day 1st month following the employee signature date
Spouse's death	Add retiree and any dependent who loses coverage under spouse's plan (1)(5)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	Proof of loss of other coverage (13)	1st day 1st month following the employee signature date
Change in Number of Dependents				
Birth	Add retiree and/or spouse and/or other dependents (1)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	None	Date of event
Adoption or placement for adoption (10)	Add retiree and/or spouse and/or other dependents (1)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	Papers from the Cabinet for Families & Children; **OR** signed and date-stamped "filed" papers from the Court; **OR** letter from adoption agency on letterhead;**OR** legal document from a US Court;**OR** official document translated into English	Date of event
Judgement, decree or administrative order relating to health coverage for a child	Add child if required under order (10)(11)(12)	ADD Form	- Adding a grandchild requires guardianship or custody papers - Adding a foster child requires placement papers from Cabinet for Families & Children **OR** a filed and dated court decree **OR** National Medical Support Notice	1st day 1st month following the employee signature date
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements)				
Spouse or Dependent loses other Employer-Sponsored Group Health Coverage (termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under employer's plan, etc.)	Add retiree, spouse, and dependents (1) if event adversely affects eligibility for coverage under spouse's or dependent's health plan (5)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	Documentation of loss of coverage (13)	1st day 1st month following the employee signature date
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (i.e. switch from salaried to hourly status)	Add retiree, spouse, and dependent (1)(5)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	Documentation of loss of coverage (13)	1st day 1st month following the employee signature date

Change in Residence				
Retiree, spouse, or dependent changes primary (6) residence and becomes eligible for KEHP	Enroll retiree, spouse, and dependent	Insurance Application	None	1st day 1st month following the employee signature date
Other Events				
Loss of other (group, individual, short-term, student) health insurance coverage (**not self-terminated**) that entitles employee or family member to be enrolled under HIPAA	Add retiree (1)(10)(11)(12)	Insurance Application	HIPAA certificate of prior coverage **OR** Letter typed on agency letterhead **OR** Letter from insurance company identifying the coverage termination date (13) and persons covered by the policy (14)	1st day 1st month following the employee signature date
Retiree, spouse, or dependent loses entitlement to Medicare, Medicaid, KCHIP, any governmental group health insurance coverage	Commence or increase coverage of the retiree, spouse, or dependent (1)(5)(10)(11)(12)	Insurance application (for retiree) **OR** ADD Form (SP or Dep)	HIPAA certificate of prior coverage **OR** termination letter from government agency under which previous coverage was held	1st day 1st month following the employee signature date
Change in Coverage under Employer Plan				
Retiree or spouse makes elections during an open enrollment period that differs from the open enrollment of the employer (7)	Retiree can make election change that "corresponds" with open enrolment election (10)	Insurance Application **OR** ADD Form	Employer letter that identifies the open enrollment period dates, the effective date of coverage or termination, and the persons who will be dropped from the plan	1st day 1st month following the employee signature date

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage is considered "Another Employer Plan", however, Veteran's Administration (VA) benefits are **NOT** considered "Another Employer Plan".

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right.

(12) Qualifying Event permits change in plan option (Standard, Capitol Choice, and Optimum). (Retiree must request an ***application*** instead of Add or Drop Form.)

(13) Loss of Coverage letter (on letterhead) must state the date insurance terminates as well as list the name(s) of those losing coverage**.** Hand-written documentation will not be accepted.

(14) Letter from insurance company should identify type of insurance coverage, reason for coverage ending, and persons who were covered by the policy. Hand-written documentation will not be accepted.

(15) Letter from employer on company letterhead naming persons covered and the date insurance becomes effective ***OR*** copy of new health insurance identification card with same information. Hand-written documentation will not be accepted.

QUALIFYING EVENT FORMS SHOULD BE SIGNED WITHIN 35 DAYS OF THE QE

If coverage terminates mid-month, you cannot sign the enrollment/Add Form to begin before the termination

Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601
(502) 848-8500
(502) 573-0199 Fax

2011 DEPENDENT ADD FORM

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. *Complete an Enrollment Application for election changes such as option changes, new coverage, new waiver or to begin a cross-reference plan.*

☐☐☐-☐☐-☐☐☐☐ **Retiree's SSN**

☐ **Cross Ref Y/N**

8	5	0	0	0

Company Number

Retiree Name (First, MI, Last) _____

To be eligible to add a dependent to your health insurance plan, you must certify that you have experienced the QE as listed here. → The QEs listed on this form are the only events that allow you to ADD dependents to your plan. To be considered an eligible dependent, your dependent MUST meet the eligibility requirements as set forth in the KEHP Handbook. Please check one of the conditions below:

- ❑ Your Legal Spouse; or
- ❑ A person of the opposite sex with whom you have established a Common Law union in a state which recognizes Common Law marriage (Kentucky does not recognize Common Law Marriage).
- ❑ Your child, stepchild, adopted/placed child, foster child or grandchild for which you have been awarded custody who is has not yet attained his/her 19th birthday.
- ❑ Your child, stepchild, adopted/paced child, foster child, or grandchild for which you have been awarded custody between the ages of 19-26 who is NOT eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer.

NOTE: The requested change may be made effective on the day of the event or after it has already occurred. Generally, the effective date will be the 1st day of the month after the date you, the retiree, signed the ADD Form.
Ex: Event on 6/17, ADD Form signed 6/20, change approved effective 7/1.

Exceptions are Birth, Birth plus, Adoption, Placement and Placement for Adoption plus, which are effective on the date of the event; and National Medical Support Notices which are effective on the 1st day of the month after notice date.

Qualifying Events: (Check one)

- ❑ Birth newborn only (60 days)
- ❑ Birth plus other dependents (35 days)
- ❑ Adoption*/ Placement for Adoption* (60 days)
- ❑ Adoption*/ Placement for Adoption* plus other dependents (35 days)
- ❑ Legal guardianship*, Administrative Order*, or court order* pertaining to health insurance+
- ❑ Marriage
- ❑ Sp/Retiree has different Open Enrollment period*+
- ❑ Sp/Dep loses other coverage*
- ❑ Sp/Dep loses KCHIP/Medicaid coverage* (60 days)
- ❑ Sp/Dep loses other government group coverage* (35 Days)
- ❑ Unmarried dependent re-establishes eligibility*
- ❑ Other _____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent
*Supporting documentation required
+Refer to QE chart for rules/effective dates

PRINT the following information for each dependent to be added:

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Relationship Code**
		M F		
		M F		
		M F		
		M F		

** Relationship Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Retiree Signature _____ Date _____ Retiree's Insurance Coordinator Signature _____ Date _____

Signatures are required below if changes to an existing cross-reference plan are being requested.

Spouse or Applicant Signature _____ Date _____ Spouse's Insurance Coordinator Signature _____ Date _____

Revision Date: 12/2/2010

Kentucky Employees' Health Plan
2011 Certification of Dependent Eligibility
Must be submitted for each dependent child ages 19 through 25

Section I: Statement of Dependency

Name of KEHP Member	Name of Dependent
KEHP Member's Social Security Number	Dependent's Social Security Number
KEHP Member's Phone Number	Dependent's Date of Birth

Section II: Dependent's Employment Status

1. Is this dependent Employed? ☐ Yes ☐ No
2. If this dependent is employed, is he/she employed full-time or part-time? ☐ Full-time ☐ Part-time
3. If this dependent is employed full-time, does his/her employer offer group health insurance for which this dependent is eligible? ☐ Yes ☐ No

   Name and address of employer:

Section III: Acknowledgement

I, the member, and I, the dependent reference above, do certify under penalty of law that the information I have provided on this affidavit is correct and complete. I understand that omissions or incorrect statements made by me on this affidavit could lead to (1) retroactive loss of benefits for the dependent named above; (2) disciplinary action, up to and including termination of employment; and (3) civil and/or criminal penalties.

I understand that this form is not an application for insurance coverage and that the purpose of this form is the establish eligibility of dependent persons named herein for the coverage provided under the Kentucky Employees' Health Plan.

I understand that this signed affidavit will be retained in my employee benefits file.

Print Name of KEHP Member	Print Name of Dependent
Signature of KEHP Member	Signature of Dependent
Date	Date

Mail to KTRS: 479 Versailles Road, Frankfort, KY 40601

Version 11/1/2010